FORM 130

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 130
600 Washington Street – 7th Floor, Boston Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

COMPLAINT OF IMPROPER CLAIMS HANDLING AGAINST AN INSURER

DIA Board #
(If Known):

The purpose of this form is to request the Department of Industrial Accidents (DIA), Office of Claims Administration to conduct a preliminary investigation into the claims handling practices of an Insurer. Upon completion of our investigation you will be notified of our findings. Please note- The DIA can only determine if the matter should be further investigated by the Division of Insurance. The DIA can **NOT** award damages or any type of award or compensation to a complainant.

1. Complainant's Name (Last, First, MI):	2. Complainant's Telephone Number:

3. Complainant's Address (No. and Street, City, State, Zip Code):

4. DIA Board Number (if known):	5. Date of Injury (mm/dd/yyyy):	6. Complainant's Social Security Number*:

7. Name of Complainant's Attorney:	8. Telephone Number of Complainant's Attorney:

9. Attorney's Address:

10. Employer's Name & Address (No. and Street, City, State, Zip Code):

12. Name & Address of Insurer's Attorney:	13. Telephone Number of Insurer's Attorney:
14. Workers' Compensation Insurance Carrier:	15. Insurance Carrier's Case File Number (if known):
16. Claims Representative's Name:	17. Claims Representative's Tel. Number:

NATURE OF COMPLAINT (attach additional sheets if necessary)
Specify dates of complaint, date claim has been paid through, any weeks not paid, etc.

18. Complainant's Signature:	**19. Date Prepared (mm/dd/yyyy):**

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents. Please Print Clearly or Type. Unreadable forms will be returned.

Form 130 - Revised 8/2001 - **Reproduce as needed.**